State of California Department of Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

## LICENSING PROGRAM

**1426 Howe Avenue, Suite 56**
**Sacramento, CA 95825-3236**
**(916) 263-2382 FAX (916) 263-2567**
www.medbd.ca.gov

## *DISABLED PHYSICIAN APPLICATION FOR EXEMPTION FROM PAYMENT OF RENEWAL FEE*

***Please print or type.***
***Illegible applications will be returned.***

FOR OFFICE USE ONLY

Fee Paid: _____ Receipt #: _____
Date Cashiered: _____ Cashier's Intl.: _____
Date Approved: _____ Reg. No: _____
Date Denied: _____
Mgr. Approval: _____ Date: _____
Enforcement Approval: ____ Yes ____ No Date: _____

| | |
|---|---|
| **Name (first, middle, last):** | |
| **Address:** Is this address currently on file with the Medical Board as your official address of record? If not, complete reverse. | |
| **Telephone FAX Number:** **FAX Number (if applicable):** | Telephone ( ) FAX ( ) |
| **Social Security Number:** | |
| **California Medical License Number:** | |

***THE FOLLOWING MUST BE COMPLETED BY YOUR ATTENDING PHYSICIAN.***

Description of disability and explanation as to how the disability prevents the applicant from practicing medicine safely. (Attach additional sheet(s), if necessary.)

Approximate date disability began: _____ The disability is: Temporary____ Permanent____

If "temporary," approximate date applicant will be able to return to practicing medicine: _____

_____ _____
Attending Physician's Name Telephone Number

_____ _____
Attending Physician's Address City State Zip

**I certify under the penalty of perjury under the laws of the State of California that the information I have provided in this application, including any supporting documents is true and correct and that I am licensed to practice in the State of California.**

_____ _____
Applicant's Signature Date

_____ _____ _____
Attending Physician's Signature Date License Number

*All items in this application are mandatory; none are voluntary. This information is requested by the Division of Licensing of the Medical Board of California. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for waiver of renewal fees, pursuant to Section 2441 of the Business and Professions Code. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental or law enforcement agencies.*

*Disclosure of your Social Security number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgement or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. In f you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.*

**BOTH PAGES OF THIS FORM MUST BE COMPLETED**

**CURRENT MAILING ADDRESS**

_____
_____
_____
_____

’ **Check here if this is a change of address** so that your record can be updated. If this is a U.S. Postal Service, P.O. box, you must list a confidential street address.

## INFORMATION AND FILING INSTRUCTIONS

Section 2441 of the Business and Professions Code provides an exemption from payment of a renewal fee if a licensee demonstrates to the satisfaction of the Board that the licensee is unable to practice medicine due to a disability. This waiver is at the discretion of the Board, may be terminated at any time, and is based on the licensee's inability to practice medicine.

The licensee and his or her attending physician are required to complete the application. If the application is approved, the license will denote "Disabled." Biennially the licensee will receive a "License Renewal Application" to complete and sign, but no fee will be required to renew this exempt license. *The holder of a disabled license cannot engage in the practice of medicine.*

At the time of application, if the applicant's physician and surgeon's license is expired, payment of all accrued renewal fees, the delinquent fee, and penalty fee must be submitted with the application. If the applicant's physician and surgeon's license has not expired, no fee is required.

When a licensee desires to return to practicing medicine, the licensee and attending physician will be required to complete an application to have the licensee removed from disabled status and returned to "active" licensure. It must be established to the satisfaction of the Board that the disability either no longer exists or does not affect the licensee's ability to practice medicine safely. At the time of application, the licensee must also submit payment of the current (active license) renewal fee.

The holder of a disabled license must comply with the Continuing Medical Education (CME) requirements, unless the holder has also applied for and been granted a CME waiver. If you wish to apply for a CME waver, please contact the Board for the appropriate forms.

FOR OFFICE USE ONLY

| Application Coordinator | Medical Consultant |
|---|---|
| **Applicant's License Verification**:<br>License Number: _____<br>Issue Date: _____<br>Expiration Date: _____<br>Enforcement Date: _____<br>**Attending Physician License Verification**:<br>License Number: _____<br>Issue Date: _____<br>Expiration Date: _____<br>Enforcement Date: _____ | _____Approved _____Denied<br>If denied, please provide reason:<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |

**CONTINUING MEDICAL EDUCATION (CME)**

In order to insure the continuing competence of licensed physicians and surgeons, the Division of Licensing shall adopt and administer standards for the continuing education of such licensees. The division shall require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at intervals of not less than four nor more than six years.

**I certify under penalty of perjury under the laws of the State of California that I read and understand the continuing medical education (CME) requirements, have completed and can document (if audited) an average of 25 hours of approved CME each calendar year, with 100 hours over the last 4 years or that I hold a permanent CME waiver from the Medical Board of California.**

_____ _____
Applicant's Signature Date